



## Qualified Medical Evaluator Complaint Form

Industrial Medical Council  
Department of Industrial Relations  
P. O. Box 8888  
San Francisco, Ca 94128-8888

### Instructions for Completing this Complaint Form

1. Legibly print or type all information.
2. Provide the name of the Qualified Medical Evaluator your complaint is against.
3. Provide the address where the examination was performed.
4. If you are complaining about the contents or the conduct of an examination, please include the medical report of the QME, if available.
5. Please sign and date the complaint form.

**Notice:** Except for the name of the physician, the remainder of the information requested is voluntary; however, the failure to provide the requested information may delay or prevent the investigation of your complaint. Please provide as much information as possible in your complaint. The Industrial Medical Council will use the information in your complaint in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies.



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**Complaint Registered Against**

*(For IMC use only)*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address where the exam took place: \_\_\_\_\_

City: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**In what capacity did the evaluator perform the examination?**

Panel Qualified Medical Evaluation ☐ Agreed Medical Evaluation ☐

Applicant's Qualified Medical Evaluation ☐ Defense Qualified Medical Evaluation ☐

**Person Registering Complaint**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Information About Your Claim**

If you are the injured worker, please list the name of the insurance company/employer and the name and telephone number of your examiner.

Name of Examiner: \_\_\_\_\_

Insurance Co. or Employer: \_\_\_\_\_

Claim Number: \_\_\_\_\_

If you are making a complaint and you are not the injured worker, please list the name of the injured worker.

Name: \_\_\_\_\_

If your complaint involves an examination performed by a Qualified Medical Examiner in a case pending before the Workers' Compensation Appeals Board, please list the case and the case number. If the WCAB has held a hearing or issued any orders about this examination, please attach the minutes of hearing or the Board order to this complaint.

Case Name: \_\_\_\_\_

Case Number(s): \_\_\_\_\_

### **Give Us the Details of Your Complaint**

Please list the details of your complaint and attach any documents that you believe would be useful for the investigation. Use as many additional sheets of paper as necessary to tell us about your complaint.

Date:\_\_\_\_\_

Signature:\_\_\_\_\_